

2005

Hospital Annual Report (HAR) - Instructions

Financial, Utilization and Services Data

HCCIS

Health Care Cost Information System



Minnesota Hospital Association



Completion and submission of this report and of the Audited Financial Statements and Medicare Cost Report are required by Minnesota Statutes, sections 144.695 - 144.703, 144.562, 144.564, 62J.321 and Minnesota Administrative Rules, Chapter 4650.

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GENERAL INFORMATION

BACKGROUND

According to the Minnesota Health Care Cost Information Act of 1984 (Minnesota Statutes, Sections 144.695 - 703), the Minnesota Department of Health (MDH) is responsible for providing accurate and reliable information about the financial, utilization, and service characteristics of hospitals in Minnesota to public policy makers, purchasers of hospital services, and the general public. Minnesota Rules, chapter 4650, defines the data that are collected. These data provide unique information that is not a part of other data collection requirements.

Minnesota Hospital Association (MHA) serves as a “voluntary nonprofit reporting organization” (VNRO) under an agreement with the Minnesota Department of Health. In this capacity, MHA staff collects and audits financial and statistical information from each hospital on the Hospital Annual Report (HAR) for MDH. In addition to the HAR, MHA collects copies of the Audited Financial Statement (AFS), and Medicare Cost Report (MCR) from hospitals and forwards them to MDH.

DATA USES

The accuracy and reliability of the data reported on the HAR is essential as is evident by its many uses. In addition to facilitating public policy decisions and assisting hospitals in comparing their financial, utilization and services data to individual and aggregated hospital data, the HAR data is used to:

- Calculate the hospital medical care surcharge
- Determine eligibility for state rural hospital grant programs
- Develop estimates of total health care spending and aggregate hospital utilization for the state of Minnesota
- Demonstrate the impact of health care reform and the cost containment strategies proposed under health reform legislation
- Assist health care providers to demonstrate to key decision makers particular areas of their costs that may be beyond their control, such as labor costs, malpractice insurance, billing and collections costs, research and education costs, and costs related to uncompensated care and charity care
- Assist health care providers in identifying trends and variances in costs

REPORTING REQUIREMENTS

All hospitals (excluding federal hospitals), psychiatric hospitals, and specialized hospitals are required to submit data. Hospitals are required to complete **all** “hospital-only” sections of the Hospital Annual Report (HAR), and submit copies of the Audited Financial Statements and Medicare Cost Report.

- Psychiatric and specialized hospitals are required to complete a shorter version of the HAR containing utilization and services information, and total operating revenue and expenses, and are **not** required to submit an Audited Financial Statement or Medicare Cost Report.

REPORTS and DUE DATES

Hospital Annual Report (HAR) for Reporting Year 2005:

Hospitals are required to submit **one** original report within 180 days after the hospital’s 2005 fiscal year end. (Minnesota Statutes, Section 144.698, Subd. 1 (6), and Minnesota Rules, part 4650.0130 subparts 1 and 5.)

Note: The **entire** HAR must be submitted at the **same** time. Although different departments within the hospital may participate in data collection efforts, all applicable sections of the report must be complete before it is submitted.

Audited Financial Statements (AFS), Medicare Costs Report (MCR), and reconciliation between the AFS and MCR for 2005:

Submit **two** copies of each report within 180 days after the 2005 fiscal year end of the health facility. (Minnesota Statutes, Section 144.698, subd. 1 (1) and (3), and Minnesota Rules, part 4650.0110, subpart 1, part 4650.011, and part 4650.0130, subpart 5.)

SUBMIT ALL REPORTS TO:

Minnesota Hospital Association
2550 University Avenue West, Suite 350-S
St. Paul, Minnesota 55114-1900
Phone: (800) 462-5393 Fax: (651) 645-0002

Upon receipt:

- MHA staff will make an initial check for completeness and overall accuracy of the HAR. If the report is incomplete, it will be returned to the preparer for revisions. A HAR is accepted only when it is received, revised, and complete.
- The HAR is then audited to verify the figures with the Audited Financial Statement and ensure accuracy and consistency in reporting throughout the report and from year to year. If figures are inaccurate, inconsistent, or cannot be verified, the preparer will be contacted for clarification/correction.
- Upon completion of the audit, the HAR data is considered final and can *only* be changed through a formal amendment process. For information about the amendment process, contact MHA or MDH.

Available upon request:

Minnesota Statutes, sections 144.695 - 144.703
Minnesota Rules, chapter 4650
Statement of Need and Reasonableness (SONAR)

For more information, contact:

Joe Schindler	Director, MHA	(651) 641-1121 (651) 645-0002 FAX
Amy L. Camp	HCCIS Administrator, MDH	(651) 282-3818 until 3-9-06 (651) 201-3575 effective 3-10-06 (651) 282-5628 until 3-9-06 (651) 201-5179 FAX effective 3-10-06

REQUEST FOR EXTENSION

If hospital personnel are unable to complete the HAR by the due date, an extension must be requested *in writing* by the due date of the HAR report, *and* must explain the reason for the extension request. An extension may be granted for a specified period of time if reasonable cause is demonstrated.

- Requests for the initial 30-day extension should be addressed to MHA.
- Additional extensions should be addressed to MDH.

INFORMATION ON COMPLETING THE HAR

LAYOUT

The Financial portion of the report includes data for both the Institution *and* Hospital.

- The Institution page is to be completed by those hospitals with affiliated facilities whose audited financial statements reflect *only* this relationship. Information for the Institution *must tie directly* to the audited financial statement.
- The Hospital segment of the financial portion includes several sections. It is *required* and must reflect information for the *hospital only*.

Many accounts throughout the formset are grayed-out and will be calculated automatically.

The Staffing, Utilization (including separate pages for Swing Bed Care and Subacute/ Transitional Care), and Services sections of the report are to be completed for the *hospital only*, and may require information from other departments of the hospital.

GENERAL

The “2005 FYE Reporting Year” column refers to the hospital’s 2005 fiscal year end and must reflect *actual* information for 2005.

Whenever reasonably possible, a hospital must report actual numbers in all categories. If it is not reasonably possible to report actual information, the hospital may estimate using reasonable methods. When an entry is an estimate, please identify it as an estimate. Note that, upon request, the hospital must provide a written explanation of the method used for the estimate. (Minnesota Rules, part 4650.0112, subpart 1c.)

Standard methods of allocation are encouraged to insure consistent data across hospitals. Allocations apply to multiple-use hospital systems including Nursing Homes, Stand-Alone Clinics, Home Health Agencies, Hospices and Ambulance Services. Items to be allocated include Natural Expenses, Adjustments and Uncollectibles, Salaries, and FTEs. An example of a standard allocation method is found in the Medicare Cost Report, Worksheet B, Part 1.

In some instances two different accounts will require identical information. When this occurs, it is referenced on each account line (e.g. both Account 0600 and Account 0790 are Total Operating Expense).

Leave accounts *blank* when the account is *not applicable* to your hospital. For example, if your hospital does not provide neonatal care or chemical dependency services, accounts for neonatal care charges and chemical dependency charges should be left blank. An exception to this is found with Account 4531, Hospital Licensed Bassinets. Hospitals with no Licensed Bassinets should record -0- for this line. However, if the account *is applicable* and the value happens to be zero, enter -0- for that account.

[Bracket] accounts that are negative such as contractual adjustments and uncollectibles, extraordinary losses, and allowance for uncollectible accounts.

Hospital Annual Report (HAR) Instructions

Hospital Identification HAR p. 1

Please list all identifying information for the facility. Critical Access Hospital (CAH) Status should be recorded.

Please report the *full name* of the hospital's Emergency Department Physician Director. If you have an Emergency Department, you *must* enter the director's name. This is required by Minnesota Rules chapter 4650.0112 subp.2a,C(3).

Certification Statement HAR p. 1

An officer of the hospital such as the Administrator, Chief Executive Officer, Chief Financial Officer, or Controller must sign this certification.

Section 1: Licensed Beds and Bassinets HAR p. 2

- #4504** Total Number of Hospital Licensed Beds: The number of beds licensed by the Department of Health, pursuant to Minnesota Statutes, sections 144.50 to 144.58.
- #4531** Total Number of Licensed Bassinets: The number of bassinets licensed by the Department of Health, pursuant to Minnesota Statutes, sections 144.50 to 144.58. If you have no licensed bassinets, enter -0-. Do **not** leave this blank.
- #7082** Total Available Beds (as of the last day of the FY 2005): The number of acute care beds that are immediately available for use or could be brought online within a short period of time. Available beds should not include: labor rooms, bassinets, post-anesthesia beds, post-operative beds, or other non-routine beds. Do not leave this blank. Note: If your hospital is Critical Access, your total Available Beds may not exceed 15 (up to 25 if you also have Swing-Beds).

Section 2: Change in Licensed Beds or Bassinets HAR p. 2

Report any *permanent* change in the number of licensed beds or bassinets during the reporting period. The requirement to report the change in licensed bassinets was added in 2001 due to the changes in Minnesota Rules, chapter 4650.

Section 3: Revenue and Expense Summary HAR p. 3

Hospitals affiliated with a nursing home, free-standing clinic, home health agency, hospice agency, ambulance service, senior living facility, or other facility or agency as indicated on the audited financial statement are required to complete this section. Hospitals with audited financial statements specific to the hospital are not required to complete this page, even if the

hospital is part of an institution. The primary purpose of this section is to verify revenue and expense accounts with the audited financial statement. If the audited financial statement does not specifically break out hospital revenue and expense from that of the other facilities of an institution, this page is used to verify institution information.

- #0201 Gross Hospital Charges from Patient Care (ties to 0740): The total charges billed by the facility for patient care regardless of whether the facility expects to collect the amount billed.
- #0207 Gross Clinic Charges from Patient Care: If the clinic *is not* an outpatient department of the hospital, the patients *are not* registered outpatients or admitted inpatients of the hospital, you *do not* bill for these services on a UB92 form, and if the clinic *is listed* in the hospital's Medicare Cost Report on worksheet S, part II as an entity of the hospital complex, this is considered Institutional revenue and should be reported here.
- #0202 Gross Home Health Revenue: If your audited financial statement includes revenue for non-hospital services provided by a licensed home health agency that is part of the same institution as the hospital, the Minnesota Department of Health requires that you report such revenue in this account.
- #0203 Gross Hospice Revenue: If your audited financial statement includes revenue for non-hospital services provided by a licensed hospice agency that is part of the same institution as the hospital, the Minnesota Department of Health requires that you report such revenue in this account.
- #7113 Gross Ambulance Services Charges from Patient Care: If the ambulance service *is not* operated by hospital-employed staff and *is listed* in the hospital's Medicare Cost Report on worksheet S, part II as an entity of the hospital complex, this is considered Institutional revenue and should be reported here.

Note: In 2000 MDH revised the rules to pull Ambulance Service charges out of hospital revenue and place it into Institution charges to make hospital revenue more comparative across the state.

If you completed this portion of the 2004 HAR but are not completing it for 2005, or if you did not complete this portion of the 2004 HAR but will be completing it for 2005, contact MHA at (800) 462-5393 for further information. In addition, if you are proposing to make an alteration to a prior year's format, please contact MHA personnel. *An error in completing this page could necessitate revising the entire financial portion of the report.*

Section 4: Non-Operating Revenue and Expense HAR p. 3

- #0333 Extraordinary Items; Gain/(Loss): Material Gains or Losses identified in the institution's Audited Financial Statement as a result of an event that is both unusual in nature and infrequent in occurrence (ex: void of bond debt, highly unusual catastrophic weather conditions).
- #0340 Other Changes to Unrestricted Net Assets (FASB's, Changes in Accounting Principles, Transfers, etc.): For this account, report the combined net effect of FASB (Financial Accounting Standards Board) changes or other items that are typically reported below the "Revenue in Excess of Expense" or "Expense in Excess of Revenue" line on the Certified

Audit's income statement. Some examples of these items are:

- Unrealized Gains/Losses on marketable securities
- Net change in unrealized gain/loss on marketable securities
- Cumulative effect of change in accounting principle
- Net assets released from restrictions
- Contributions/donations released for property acquisitions
- Transfers for acquisition of property and equipment
- Donated equipment
- Net transfers to/from other entities

To standardize institutional reporting, report the *net* effect of these changes in Account 0340.

FINANCIAL INFORMATION: HOSPITAL (Hospital Patient Care Services and Other Patient Care Services Provided by the Hospital)

All sections identified as **HOSPITAL** must be completed with *hospital-only* information according to Minnesota Rules, part 4650.0112. If a hospital's audited financial statement shows evidence of affiliation with a free-standing clinic, nursing home, ambulance service, hospice agency, home health agency, or other facility, the hospital information must be reported separately including allocated expenses for general and administrative, medical records, etc. If a hospital's audited financial statement does not show evidence of affiliation with another facility, and the data provided on the HAR does not directly tie to the audited financial statement, please contact MHA staff before proceeding with the formset.

Section 5: Physician Services Schedule HAR p. 4

This supplemental information will be provided to the Department of Human Services (DHS), the agency that is responsible for administration of the Medical Care Surcharge, for their consideration. It is the responsibility of DHS and the legislature to determine criteria for taxation and which data items will be used in the calculation of the Medical Care Surcharge.

This section provides a schedule for reporting Physician Services revenues, which are revenues received by the hospital for services performed by physicians who are employees of the hospital, and/or revenues for physician services billed and received by the hospital when contractual agreements or arrangements stipulate payment to physicians by the hospital through a set fee or other compensation (ex: ER phys fees, radiologist, pathologist, anesthesiologist, EKG/EEG physicians). Administrative agreements in which the hospital processed physician bills, which are paid to the physician, *do not* constitute physician services revenue nor should it be included in total hospital revenue.

In order to report in this schedule, physician charges, discounts, uncollectibles and bad debt must be included in the following accounts: charges (accounts #0740 and #0841), discounts and uncollectibles (accounts #0760 and #0741), and bad debt (account #0621). In addition, if there are Managed Care Organization patient charges (account #0842), there *must* be corresponding Managed Care Organization patient adjustments (account #0742).

#7117 Inpatient Gross Physician Charges: includes all Physician patient service charges provided

to admitted inpatients of the hospital.

#7118 Outpatient Gross Physician Charges: includes all Physician patient service charges provided to registered outpatients of the hospital.

#7087 Physician Expense: includes direct expenses (i.e., Salaries, Benefits and Purchased Services) incurred through the contractual agreement with physicians providing professional services for hospital patients. Only expenses for physicians who bill for their services under accounts 5501 and 0740 can be considered in this line (ex: ER Physicians). Estimates of expenses based on hospital revenue percentages may be substituted if actual expenses are unavailable.

Section 6: Other Billable Professional Services Schedule HAR p. 5

This supplemental information will be provided to the Department of Human Services (DHS), the agency that is responsible for administration of the Medical Care Surcharge, for their consideration. It is the responsibility of DHS and the legislature to determine criteria for taxation and which data items will be used in the calculation of the Medical Care Surcharge.

This section provides a schedule for reporting Other Billable Professional Services revenues, which are revenues received by the hospital for services performed by other billable professionals who are employees of the hospital, and/or revenues for other billable professional services billed and received by the hospital when contractual agreements or arrangements stipulate payment to other billable professionals by the hospital through a set fee or other compensation. (Administrative agreements in which the hospital processed other billable professionals bills, which are paid to the other billable professional, do not constitute other billable professionals services revenue nor should it be included in total hospital revenue.)

Other Billable professional services includes revenues from billable mid-level practitioners whose scope of practice allows them to practice independent of direct physician supervision (ex: CRNA, nurse practitioner). This applies to billable mid-level practitioners, whether they are employed by the hospital or under contract with the hospital, where the charges are billed and received by the hospital, unless the hospital acts merely as a billing agent.

In order to report in this schedule, other billable professional charges, discounts, uncollectibles and bad debt must be included in the following accounts: charges (accounts #0740 and #0841), discounts and uncollectibles (accounts #0760 and #0741), and bad debt (account #0621). In addition, if there are Managed Care Organization patient charges (account #0842), there *must* be corresponding Managed Care Organization patient adjustments (account #0742).

#7119 Inpatient Gross Other Billable Professional Charges: includes all Other Billable Professional patient service charges provided to admitted inpatients of the hospital.

#7120 Outpatient Gross Other Billable Professional Charges: includes all Other Billable Professional patient service charges provided to registered outpatients of the hospital.

#7088 Other Billable Professional Expense: includes direct expenses (i.e., Salaries, Benefits and Purchased Services) incurred through the contractual agreement with CRNAs, PAs, NPs or Midwives providing services for hospital patients. Only expenses for other professionals who bill for their services under accounts 7061 and 0740 can be

considered in this line. Estimates of expenses based on hospital revenue percentages may be substituted if actual expenses are unavailable.

Section 7: Reference Lab/Reference Radiology Services Schedule HAR p. 6

This supplemental information will be provided to the Department of Human Services (DHS), the agency that is responsible for administration of the Medical Care Surcharge, for their consideration. It is the responsibility of DHS and the legislature to determine criteria for taxation and which data items will be used in the calculation of the Medical Care Surcharge.

This section provides a schedule for reporting Reference Lab/Reference Radiology revenues, which are revenues received by the hospital for services performed by the hospital's lab or radiology department for patients that are neither admitted inpatients nor registered outpatients of the hospital.

In order to report in this schedule, Reference Lab/Reference Radiology charges, discounts, uncollectibles and bad debt must be included in the following accounts: charges (accounts #0740 and #0841), discounts and uncollectibles (accounts #0760 and #0741), and bad debt (account #0621). In addition, if there are Managed Care Organization patient charges (account #0842), there *must* be corresponding Managed Care Organization patient adjustments (account #0742).

#7085 Reference Lab/Reference Radiology Expense: includes direct expenses incurred by the hospital in providing outside Lab/Radiology services for non-hospital patients. These services are usually provided under a contractual basis with other organizations such as clinics, nursing homes, neighboring hospitals and other health care providers. Types of expenses include direct costs such as salaries, benefits, supplies, purchased services, etc. Calculations of expenses based on the Lab Cost to Charge Ratio found in the Medicare Cost Report, Worksheet C, Part I applied to Gross Reference Lab/Reference Radiology Charges may be used. Estimates of expenses based on hospital revenue percentages may be substituted if actual expenses are unavailable.

Section 8: DME/Retail Pharmacy Supplies Services Schedule HAR p. 6

This supplemental information will be provided to the Department of Human Services (DHS), the agency that is responsible for administration of the Medical Care Surcharge, for their consideration. It is the responsibility of DHS and the legislature to determine criteria for taxation and which data items will be used in the calculation of the Medical Care Surcharge.

This section provides a schedule for reporting DME (Durable Medical Equipment) and/or Retail Pharmacy Supplies revenues, which are revenues received by the hospital for services provided by the hospital for patients that are neither admitted inpatients or registered outpatients of the hospital.

In order to report in this schedule, DME and/or Retail Pharmacy Supplies charges, discounts, uncollectibles, and bad debt must be included in the following accounts: charges (accounts

#0740 and #0841), discounts and uncollectibles (accounts #0760 and #0741), and bad debt (account #0621). In addition, if there are Managed Care Organization patient charges (account #0842), there *must* be corresponding Managed Care Organization patient adjustments (account #0742).

#7086 Durable Medical Equipment (DME)/Retail Pharmacy Expense: includes direct expenses incurred by the hospital in providing DME/Retail Pharmacy services for non-hospital patients. These services are provided to non-hospital patients usually on a cash basis. Types of expenses include direct costs such as salaries, benefits, supplies, pharmaceutical drugs, purchased services, etc. Calculations of expenses based on the DME or Pharmacy Cost to Charge Ratio found in the Medicare Cost Report, Worksheet C, Part I applied to Gross DME/Retail Pharmacy Charges may be used. Estimates of expenses based on hospital revenue percentages may be substituted if actual expenses are unavailable.

Section 9: Natural Expense Summary HAR p. 7

- #0601 Salaries and Wages:** Salaries and wages should include only actual W-2 earnings. These salaries should reflect only the hospital portion of staff allocations between the hospital and affiliated organizations such as a nursing home or clinic.
- #0621 Provision for Bad Debts:** The provision for actual or expected doubtful accounts resulting from the extension of credit. This line should tie to the Provision for Bad Debts on the income statement of the hospital's audited financial statements (unless charity care is included in this line on your *financial* statement). Per Minnesota Rules chapter 4650.0117, in determining whether to classify charity care as bad debt expense, the facility must consider the following points:
- A. The facility must presume that the patient is able and willing to pay until and unless the facility has reason to consider this a charity care case under its charity care policy and the facility classifies this as a charity care case; and
 - B. The facility includes as bad debt expense unpaid deductibles, co-insurance, co-payments, and non-covered services and any other unpaid patient responsibilities.
- #0625 Malpractice Expenses:** All costs of malpractice including malpractice insurance self-insurance expenses including program administration, and malpractice losses not covered by insurance, including deductibles and malpractice attorney fees.
- #0622 Medical Care Surcharge:** The expenses incurred under Minnesota Statutes, sections 147.01, subdivision 6, and 256.9657. For purposes of reporting, medical care surcharge is an operating expense.
- #0623 MinnesotaCare Tax:** Expenses for the MinnesotaCare tax under Minnesota Statutes, section 295.52 and 295.582.
- #0619 Other Expenses:** Other expenses should encompass any residual hospital specific expenses not included in the other distinct natural expense classifications. A lump sum allocation of all expenses to an affiliated entity may not be netted into this line but must be properly designated to their correct expense categories. This figure *cannot* be negative.

Section 10: Patient Care Charge Summary HAR p. 8

Although Charity Care is not recognized as revenue by the American Institute of Certified Public Accountants (AICPA), for this report you are required to gross-up total patient charges (Accounts 0740 - section 6, 0850 - section 14, and 0860 - section 15) to include the amount of charity care write-offs. The accurate and consistent reporting of charity care is important for monitoring hospital industry trends in uncompensated care and evaluating the impact of market changes and health care reforms. Net patient revenue will not be affected because there is a corresponding account in Section 7: Primary Payer Adjustments & Uncollectibles to report charity care as an adjustment (#0762).

If your hospital reports patient charges, you are also required to report patient days and admissions.

- #7224** Med/Surg Care Charges: (formerly identified as 0701 Adult Care Charges) Room and Board Charges for the hospital's Medical and Surgical Patients.
- #7129** ICU/CCU Care Charges: Room and Board Charges for the hospital's Intensive Care Unit/Coronary Care Unit patients. This line is the combination of former accounts 0704 Intensive Care Charges, and 0707 Coronary Care Charges.
- #0714** Neonatal Care (exclude routine nursery) Charges: Includes neonatal intensive care unit (NICU) charges and all infant care charges with care levels higher than a routine nursery.
- #7091** Reference Lab and Reference Radiology Services Charges: Charges for the sale of reference laboratory services or radiology services to non-hospital patients.
- #7092** DME and Retail Pharmacy Supplies Charges: Charges for the sale of durable medical equipment and retail pharmacy supplies to non-hospital patients.
- #7094** Physician Professional Fees: Charges related to billable professional physician services only (ex: ER phys fees, radiologist, pathologist, anesthesiologist, EKG/EEG physicians).
- #7095** Other Billable Professional Fees: Charges related to billable professional (non-physician) services only (ex: CRNA, nurse practitioner).
- #0740** Total Charges from Patient Care: The total charges billed by the facility for patient care regardless of whether the facility expects to collect the amount billed. Per Minnesota Rules chapter 4650.0102, subpart20f, "Hospital patient care services charges" means the total charges billed by the hospital for care provided to admitted inpatients and registered outpatients by the hospital operating under its Minnesota hospital license. Charges are counted in hospital patient care services revenue regardless of whether the hospital expects to collect the amount billed. Hospital patient care services revenue includes charges for hospital routine inpatient, routine outpatient, and ancillary services.

Section 11: Specialty Patient Charges HAR p. 9

- #7236** Inpatient Cardiac Care Charges: Patient Charges relating to diseases and disorders of the Circulatory System and Heart Transplants.
- #7238** Inpatient Orthopedic Care Charges: Patient Charges relating to diseases and disorders of the Musculoskeletal System and Connective Tissue.
- #7240** Inpatient Neurology Care Charges: Patient Charges relating to diseases and disorders of

the Nervous System.

Section 12: Patient Care Charge Summary by Age HAR p. 9

- #7225** Adult Care Charges (18+): Total Hospital Patient Care Services Charges for all patients 18 years of age and older. This includes all Routine (Medical/Surgical Room and Board), Specialty (ICU/CCU, Chemical Dependency, Rehabilitation, Mental Health/Psych, Swing Bed and Transitional Bed Room and Board) and both Inpatient & Outpatient Ancillary Charges. Exclude all Fees for Physicians and Other Billable Professionals in addition to Reference Lab/Reference Radiology Services Charges and DME/Retail Pharmacy Supplies Charges.
- #7127** Pediatric and Adolescent Care Charges (including Neonatal): Total Hospital Patient Care Services Charges for all patients less than 18 years of age. This includes all Routine (Medical/Surgical Room and Board), Specialty (ICU/CCU, Neonatal, Chemical Dependency, Rehabilitation, Mental Health/Psych, Nursery, Swing Bed and Transitional Bed Room & Board) and both Inpatient & Outpatient Ancillary Charges. Exclude all Fees for Physicians and Other Billable Professionals in addition to Reference Lab/Reference Radiology Services Charges and DME/Retail Pharmacy Supplies Charges. This is *not* just for Pediatric specialty hospitals only. ***This is to be completed by all hospitals.***

Section 13: Primary Payer Adjustments & Uncollectibles HAR p. 10

A managed care organization is defined in Minnesota Statutes, Chapter 62Q.01, subd. 5, as (1) a health maintenance organization operating under chapter 62D; (2) a community integrated service network as defined under section 62N.02, subdivision 4a; or (3) an insurance company licensed under chapter 62A, (4) a nonprofit health service plan corporation operating under 62C, (5) a fraternal benefit society operating under chapter 64B, or (6) any other health plan company, to the extent that it covers health care services delivered to Minnesota residents through a preferred provider organization or a network of selected providers.

“Managed Care Organizations Adjustments & Uncollectibles” includes adjustments for such organizations as HMOs and insurance companies delivering care through a PPO or provider network.

Below is a partial listing of some of these organizations in Minnesota:

- Blue Plus
- Medica
- First Plan of MN
- Metropolitan Health Plan
- HealthPartners
- Group Health, Inc.
- Avera Health Plan of MN
- UCARE MN
- Preferred One Community Health Plan
- Sioux Valley Health Plan of MN

The far right column on the formset shows a link labeled “Audit Check.” Clicking on this link will take you to another tab in the workbook where you can review your adjustments to charges ratio. This is for your information only to aid you in completion of the formset. If your hospital does not fall within the stated ranges, you may be contacted by MHA staff for possible corrections.

#7230 Total Non-Managed Care Adjustments: Summary of three subsequent accounts: Medicare Adjustments (Non-Managed Care); MA/GAMC/MinnesotaCare Adjustments (Non-Managed Care); and Commercial Insurers, Nonprofit health Plans Adjustments. This line does not need to be completed! It will populate itself as the subsequent lines are filled in.

#0741 Medicare Adjustments (Non-Managed Care): Difference between Patient Charges billed to and payments received from Medicare intermediaries such as Noridian Administrative Services for Medicare Patients only.

MDH is frequently asked to provide data on the utilization and financial trends for MA, GAMC, and MinnesotaCare. Eligibility and payment policies related to these programs vary greatly. It is important that these categories be separated, so that we have the ability to analyze trends by program types particularly as eligibility for the programs change. This information is frequently requested by legislators and other state analysts to assist them in policy formation on a program level. With recent budget cuts, these requests have increased in frequency. This information needs to be collected separately, by program, for us to fulfill requests for data and to describe trends for each program.

#0744 MA/GAMC/MinnesotaCare Adjustments (Non-Managed Care): Total Adjustments for Medical Assistance, General Assistance, and MinnesotaCare Non-Managed Care accounts. Hospitals that do not have individual program itemizations for the MA (line # 7136), GAMC (line # 7137) and MinnesotaCare (line # 7138) Non-Managed Care programs should leave the program specific lines blank and enter the total in this line. This cell is not locked.

#7136 MA Adjustments (Non-Managed Care): Difference between Patient Charges billed to the Minnesota Department of Human Services and payments received from DHS for non-PMAP Medicaid Patients only.

#7137 GAMC Adjustments (Non-Managed Care): Difference between Patient Charges billed to the Minnesota Department of Human Services and payments received from DHS for non-PGAMC General Assistance Medical Care Patients only.

#7138 MinnesotaCare Adjustments (Non-Managed Care): Difference between Patient Charges billed to the Minnesota Department of Human Services and payments received from DHS for non-PMAP MinnesotaCare Patients only.

#0748 Commercial Insurers, Nonprofit Health Plans Adjustments:

- Commercial insurers include insurers, corporations, or associations providing health insurance such as Allstate, State Farm, etc.
- Nonprofit corporation insurers such as Blue Cross Blue Shield (excluding BCBS HMO products).

#0747 Total Managed Care Adjustments (e.g. HMO’s & PPO’s): Difference between Patient Charges billed to and payments received from Managed Care Organizations. These can

include standard Managed Care Organizations such as Medica, Health Partners, etc. and also Medicare and Medicaid PMAP companies.

- #0743** PMAP/PGAMC/MinnesotaCare Managed Care Organization Adjustments: Total Adjustments for Prepaid Medical Assistance, Prepaid General Assistance Medical Care, and Prepaid MinnesotaCare Programs accounts. Hospitals that do not have individual program itemizations for PMAP (line # 7139), PGAMC (line # 7140) and MinnesotaCare (line # 7141) programs should leave the program specific lines blank and enter the total in this line. This cell is not locked.
- #7139** PMAP Adjustments: Difference between Patient Charges billed to and payments received from third party administrators for PMAP (Prepaid Medical Assistance Program) Medicaid Patients only.
- #7140** PGAMC Adjustments: Difference between Patient Charges billed to and payments received from third party administrators for PGAMC (Prepaid General Assistance Medical Care) Patients only.
- #7141** MinnesotaCare Managed Care Adjustments: Difference between Patient Charges billed to and payments received from third party administrators for Prepaid MinnesotaCare Patients only.
- #7410** Self Pay Discounts: This includes small balance write offs. Discounts associated with patients without insurance or who were not covered for hospital services that were provided. Do not include charges from accounts written off to charity care allowances, bad debt expense or staff courtesy discounts.
- #0762** Charity Care Adjustments: The total dollar amount that would have been charged by a facility for rendering free or discounted care to persons who cannot afford to pay and for which the facility did not expect payment. For purposes of reporting under Minnesota Rules, chapter 4650.0112, charity care adjustments are included in adjustments and uncollectibles.

To determine what meets the requirements for reporting Charity Care on this report, see Minnesota Rules chapter 4650.0115.

Note: Charity care allowances should include all *Hill Burton* obligations.

Charity care is a **required** field in the HAR and **cannot** be reported in 0621 Bad Debt Expense.

- #0751** Other Payers Adjustments and Uncollectibles: This category is for the payers that are not already identified in the breakouts for Non-Managed Care, Managed Care, and Individual (Self Pay). This would include Champus, Workman's Comp., Auto, etc. for each of the respective sections: Adjustments, Charges, Days, and Admissions. Please note that Commercial and Private payers are **not** reported on the Other Payers lines.

Section 14: Net Patient Revenue HAR p. 11

- #0750** Net Patient Revenue: Patient care revenues expected to be collected after accounting for discounts and allowances. HAR net patient revenue should tie to net patient service revenue located on the statement of revenue and expense or combined statement of operations in the hospital's audited financial statements. ***In the absence of hospital***

specific audited financial statements, an internal hospital specific income statement or audit statement reconciliation should be provided.

Section 15: Other Operating Revenue HAR p. 11

This section refers to revenue derived from the daily operation of the hospital as a result of non-patient care services. Specific examples include space rental, sale of medical and pharmacy supplies to non-patients, medical record transcription fees, operation of a hospital cafeteria, parking lot/ramp fees, gift shop revenues, auxiliary functions, public phone proceeds, recovery of radiology silver, billing services for other health care entities.

- #0775** Donations and Grants for Charity Care: Revenues from an individual, group, foundation, government entity, or corporate donor that are designated by the donor for providing charity care.
- #0776** Percentage of Donations/Grants for Charity Care - Public: Report only the **percentage** in the space provided; do not enter revenue amounts in the reporting year column.
- #0777** Percentage of Donations/Grants for Charity Care - Private: Report only the **percentage** in the space provided; do not enter revenue amounts in the reporting year column.
- #0778** Private Donations and Grants for Operations: Revenues from an individual, group, foundation, or corporate donor that are designated for supporting the continued operation of the facility. Donations and grants for operations do **not** include funding for charity care.
- #0772** Public Funding for Operations: Revenues from taxes or other municipal, county, state, or federal government sources, including grants and subsidies, that are designated for supporting the continued operation of a facility. Public funding for operation does **not** include funding for charity care. For purposes of reporting, public funding for operation is operating revenue. This account includes hospital grants such as the Sole Community Hospital Financial Assistance Grant, the Rural Hospital Planning and Transition Grant, and Medical Education and Research Costs (MERC) funds (Minnesota Statutes 62J.694)

Section 16: Operating Income HAR p. 11

- #0780** Operating Revenue: The sum of net patient revenue and other income received as part of the normal day-to-day operation of the facility.
- #0790** Operating Expense: All costs directly associated with providing patient care or other services that are part of the normal day-to-day operation of the facility. Account line 0790 ties to account 0600 on page 8 of the HAR.

Section 17: Non-Operating Revenue: HAR p. 12

This section refers to revenue that is not related to patient care activities or daily hospital operations. Examples of non-operating revenue include interest income, non-operating donations and grants, unrestricted donations, and **actual** and **realized** gains from the sale of either assets or investments.

- #0806** Non-Operating Donations and Grants: Revenues from an individual, group, foundation, or corporate donor that are not designated for a specific purpose or are designated for a purpose not directly related to the normal day-to-day operations of the facility.
- #0819** Non-Operating Public Funding: Revenues from taxes or other municipal, county, state, or federal government sources, including grants and subsidies, that are not designated for a specific purpose or are designated for a purpose not directly related to the normal day-to-day operations of the facility.
- #0820** Non-Operating Revenue: All income received that is not directly related to the normal day-to-day operations of the facility.

Section 18: Non-Operating Expense HAR p. 12

This section refers to expense that is *not* related to patient care activities or daily hospital operations. Examples of non-operating expense include *actual* and *realized* losses from the sale or disposal of either assets or investments.

- #0830** Non-Operating Expense: All costs not directly associated with the normal day-to-day operations of the facility.

Section 19: Revenue in Excess of Expenses HAR p. 12

- #0831** Extraordinary Items; Gain/(Loss): Material Gains or Losses identified in the hospital's Audited Financial Statement as a result of an event that is both unusual in nature and infrequent in occurrence (ex: void of bond debt, highly unusual catastrophic weather conditions).
- #0840** Other Changes to Unrestricted Net Assets (FASB's, Changes in Accounting Principles, Transfers, etc.): For this account, report the combined net effect of FASB (Financial Accounting Standards Board) changes or other items that are typically reported below the "Revenue in Excess of Expense" or "Expense in Excess of Revenue" line on the Certified Audit's income statement. Some examples of these items are:
- Unrealized Gains/Losses on marketable securities
 - Net change in unrealized gain/loss on marketable securities
 - Cumulative effect of change in accounting principle
 - Net assets released from restrictions
 - Contributions/donations released for property acquisitions
 - Transfers for acquisition of property and equipment or donated equipment
 - Net transfers to/from other entities

To standardize hospital reporting, report the *net* effect of these changes in Account 0840.

Section 20: Primary Payer Charges Summary HAR p. 13

The far right column on the formset shows a link labeled "Audit Check." Clicking on this link will take you to another tab in the workbook where you can review your adjustments to charges ratio. This is for your information only to aid you in completion of the formset. If your hospital does not fall within the stated ranges, you may be contacted by MHA staff for possible

corrections.

#7232 Total Non-Managed Care Charges: Summary of three subsequent accounts: Medicare Charges (Non-Managed Care); MA/GAMC/MinnesotaCare Charges (Non-Managed Care); and Commercial Insurers, Nonprofit health Plans Charges. This line does not need to be completed! It will populate itself as the subsequent lines are filled in.

#0841 Medicare Charges (Non-Managed Care): Patient Charges billed to Medicare intermediaries such as Noridian Administrative Services for Medicare Patients only.

MDH is frequently asked to provide data on the utilization and financial trends for MA, GAMC, and MinnesotaCare. Eligibility and payment policies related to these programs vary greatly. It is important that these categories be separated, so that we have the ability to analyze trends by program types particularly as eligibility for the programs change. This information is frequently requested by legislators and other state analysts to assist them in policy formation on a program level. With recent budget cuts, these requests have increased in frequency. This information needs to be collected separately, by program, for us to fulfill requests for data and to describe trends for each program.

#0843 MA/GAMC/MinnesotaCare Patient Charges (Non-Managed Care): Total Charges billed by the hospital for Medical Assistance, General Assistance, and MinnesotaCare Non-Managed Care patients. Hospitals that do not have individual program itemizations for the MA (line # 7142), GAMC (line # 7143) and MinnesotaCare (line # 7144) Patient Care Non-Managed Care programs should leave the program specific lines blank and enter the total in this line. This cell is not locked.

#7142 MA Patient Charges (Non-Managed Care): Patient Charges billed to the Minnesota Department of Human Services for non-PMAP Medicaid Patients only.

#7143 GAMC Patient Charges (Non-Managed Care) Patient Charges billed to the Minnesota Department of Human Services for non-PGAMC General Assistance Medical Care Patients only.

#7144 MinnesotaCare Patient Charges (Non-Managed Care): Patient Charges billed to the Minnesota Department of Human Services for non-PMAP MinnesotaCare Patients only.

#0846 Commercial Insurers, Nonprofit Health Plans Patient Charges:

- Commercial insurers include insurers, corporations, or associations providing health insurance such as Allstate, State Farm, etc.
- Nonprofit corporation insurers such as Blue Cross Blue Shield (excluding BCBS HMO products)

#0845 Total Managed Care Organizations Patient Charges: (For definitions of Managed Care Organizations, please refer to Section 9, page 13 of the Instructions.) Total Patient Charges billed to Managed Care Organizations. These can include standard Managed Care Organizations such as Medica, Health Partners, etc. and also Medicare and Medicaid PMAP companies.

#0854 PMAP/P GAMC/MinnesotaCare Managed Care Patient Charges: Total Patient Charges for Prepaid Medical Assistance, Prepaid General Assistance, and MinnesotaCare Managed Care accounts. Hospitals that do not have individual itemizations for the PMAP, PGAMC and MinnesotaCare Managed Care programs should leave the program specific lines blank and enter the total in this line. This cell is not locked.

- #7145 PMAP Managed Care Patient Charges: Patient Charges billed to third party administrators for PMAP (Prepaid Medical Assistance Program) Medicaid Patients only.
- #7146 PGAMC Managed Care Patient Charges: Patient Charges billed to third party administrators for PGAMC (Prepaid General Assistance Medical Care) Patients only.
- #7147 MinnesotaCare Managed Care Patient Charges: Patient Charges billed to third party administrators for PMAP MinnesotaCare Patients only.
- #0847 Other Payers: Patient Charges: This category is for the payers that are not already identified in the breakouts for Non-Managed Care, Managed Care, and Individual (Self Pay). This would include Champus, Workman's Comp., Auto, etc. for each of the respective sections: Adjustments, Charges, Days, and Admissions. Please note that Commercial and Private payers are *not* reported on the Other Payers lines.

Section 21: Inpatient/Outpatient/Other Charges Summary HAR p. 14

Reported in this section are Total Patient Charges broken down by either Inpatient or Outpatient, or Other Charges. Total Charges must tie to account 0740.

- #0851 Inpatient Charges: All inpatient charges that are included in Hospital Patient Care Services Charges (7090) and Physician Professional Fees (7094) and Other Billable Professional Fees (7095) (professional services codes). These charges are to be broken out further by hospital patient care services and professional patient care services.
- #7108 Inpatient Charges - Hospital Patient Care Services: Inpatient charges that are not designated as Physician, CRNA, NP, PA, Midwife, or Chemical Dependency Counselor professional charges.
- #7109 Inpatient Charges - Professional Patient Care Services: Inpatient charges that are designated as Physician, CRNA, NP, PA, Midwife, or Chemical Dependency Counselor professional charges.
- #0853 Outpatient Charges: All outpatient charges that are included in Hospital Patient Care Services Charges (7090) and Professional Physician Fees (7094) and Other Billable Professional Fees (7095) (professional services codes). These charges are to be broken out further by hospital patient care services and professional patient care services.
- #7110 Outpatient Charges - Hospital Patient Care Services: Outpatient charges that are not designated as Physician, CRNA, NP, PA, Midwife, or Chemical Dependency Counselor professional charges.
- #7111 Outpatient Charges - Professional Patient Care Services: Outpatient charges that are designated as Physician, CRNA, NP, PA, Midwife, or Chemical Dependency Counselor professional charges.
- #7112 Other Patient Charges: Sum of 7091 + 7092 + 7096. All other patient charges that are included in Hospital Patient Care Services (0740) that are designated as either Reference Lab/Reference Radiology (7091), DME/Retail Pharmacy (7092), or Other Patient Care Services Charges (7096).

Section 22: Inpatient/Outpatient Adjustment Summary HAR p. 14

- #0752 Inpatient Adjustments & Uncollectibles: Calculation of the Adjustment & Uncollectible

percentage of the hospital Inpatient Charges. This is automatically calculated.
Calculation: $(0851/0860)*0760$.

#0754 Outpatient Adjustments & Uncollectibles: Calculation of the Adjustment & Uncollectible percentage of the hospital Outpatient Charges. This is automatically calculated.
Calculation: $(0853/0860)*0760$.

Section 23: Outpatient Charges Summary HAR p. 14

"Outpatient registration" means a documented acceptance of a patient by a facility for the purpose of providing outpatient services in an outpatient or ancillary department, including documented acceptance for the provision of emergency and outpatient surgery services. An outpatient registration may involve the provision of more than one outpatient service, and a patient may have more than one outpatient registration per day. Outpatient registration does not include failed appointments or telephone contacts.

The far right column on the formset shows a link labeled "Audit Check." Clicking on this link will take you to another tab in the workbook where you can review your Average Charge per Registration. The average range is also noted for you to compare your hospital with the state average. This is for your information only to aid you in completion of the formset. If your hospital does not fall within the stated ranges, you may be contacted by MHA staff for possible corrections.

#0871 Outpatient Registration Charges: Those charges billed by the hospital for care extended to patients by an outpatient department. Outpatient services may include such services as physical therapy, speech therapy, occupational therapy, CAT scans, MRIs, and dialysis. Upper and lower GI outpatient diagnostic procedures (colonoscopy, sigmoidoscopy, etc.) should also be included in this account.

#0872 Emergency Room Registrations Charges: Charges billed by the hospital for emergency room care extended to patients. Report *only* emergency department charges on this line and report the corresponding ancillary charges in account 0876: All Other Ancillary Outpatient Charges.

#0873 Outpatient Surgery Registrations Charges: Charges billed by the hospital for services rendered by departments such as outpatient surgery (or same day surgery), outpatient anesthesia, and outpatient post anesthesia recovery.

#0876 All Other Ancillary Outpatient Charges: This is intended to be an all inclusive or "other" category in which you are to report charges for services that cannot be directly tied to the categories provided in Accounts 0871 - 0873. Examples of services for which charges may be reported in this category are outpatient pharmacy, supplies charged to patients, laboratory, and x-ray. The reason for this category is to ensure that these services are not inappropriately allocated to the other outpatient categories thereby inadvertently inflating the charges.

Section 24: Hospital Employed Staffing by Employee Classification HAR p. 15

This section requires you to report W-2 salaries, FTEs, and FTE vacancies by designated

employee classifications.

Note: Report **only** the number of FTEs in the corresponding employee classifications for which salaries and wages are reported.

In many cases, an institution shares staff between the hospital and another facility such as a nursing home. The salaries & wages and corresponding FTEs reported in this section should reflect only the average percentage of time devoted **to the hospital** for those shared staff members employed by the institution. For example, a physical therapist that is employed by the institution as a full-time employee, but devotes 50% time to the hospital and 50% time to the nursing home, should be reported in this section as .5 FTE and 50% of the physical therapist's salary & wages should be allocated to the hospital.

Full-Time Equivalent Employee (FTE): An employee or any combination of employees that are paid by the facility for 2,080 hours of employment per year.

FTE Vacancies: Any **budgeted** position (based on 2,080 hours or a percentage of 2,080 hours) that was unused during the fiscal year.

The far right column on the formset shows a link labeled "Audit Check." Clicking on this link will take you to another tab in the workbook where you can review your average salary per FTE. The average range is also noted for you to compare your hospital with the state average. This is for your information only to aid you in completion of the formset. If your hospital does not fall within the stated ranges, you may be contacted by MHA staff for possible corrections.

Employee Classifications:

Nurse Anesthetist (Accounts 2121/2131/2171): The qualifications generally required for a nurse anesthetist include graduation from an accredited school of nursing, graduation from an accredited program in nurse anesthesia, current licensure by the Minnesota Board of Nursing as a registered nurse, and certification as a CRNA by the American Association of Nurse Anesthetists.

Nurse Practitioner (Accounts 2026/2036/2076): The qualifications generally required for a nurse practitioner include graduation from an accredited school of nursing, current licensure by the Minnesota Board of Nursing as a registered nurse, and certification as a nurse practitioner.

Nursing Assistant/Aide (Accounts 2023/2033/2073): The qualifications generally required for a nursing assistant/aide include completion of an accredited nursing assistant training program and registered as a nursing assistant.

Pharmacist (Accounts 2027/2037/2077): The qualification generally required for a pharmacist is graduation from an accredited 5-year program in pharmacy. This classification includes pharmacists only. Pharmacy technicians and other pharmacy personnel should be included in the All Other Personnel classification (accounts 2128/2138/2177).

Physician (Accounts 2024/2034/2074): Includes medical interns, medical residents, and all other physicians (Doctors of Medicine or Doctors of Osteopathic Medicine) in all physician specialties.

Physician Assistant (Accounts 2028/2038/2078): The qualifications generally required for a physician assistant include Minnesota registration to practice as a physician assistant and national certification by the National Commission of Physician Assistants.

Occupational Therapists (Accounts 2122/2132/2172): The qualifications generally required for an occupational therapist include a bachelor's degree, registration as an occupational therapist with the American Occupational Therapy Association, and registered with the State of Minnesota as an occupational therapist.

Physical Therapist (Accounts 2123/2133/2173): The qualifications generally required for a physical therapist include being registered with the Minnesota State Board of Medical Examiners as a physical therapist.

Laboratory Technologist/Technician (Accounts 2125/2135/2175): This classification includes both laboratory technologists and technicians.

Administrator (Account 2176): Record any budgeted position that has been unfilled during the fiscal year.

All Other Personnel (Accounts 2128/2138/2177): This classification includes salaries & wages and FTEs for employees not specifically designated by the other employee classifications such as hospital administrative staff, dietary staff, housekeeping, etc.

Section 25: Hospital Employed Staffing by Employee Classification: HAR p. 16

This section asks for actual *employees* rather than FTEs. The total number of employed staff on this page will *not* tie to the total number of FTEs on page 15. The employed staff figure will be a larger number.

- List the total number of active employees in their appropriate categories as of the last pay period of the fiscal year.
- In some cases, an institution shares staff between the hospital and another facility such as the nursing home. This probably does not affect the total number of hospital employees.
- For definitions of the Employee Classifications, please reference Section 24, starting on page 19 of the Instructions.

Section 26: Consultant/Contract Staffing by Employee Classification HAR p. 17

This section asks for amounts of contract dollars and the associated FTEs covered by that contract.

- List the total contract dollars and the number of Contract FTEs in their appropriate categories as of the last pay period of the fiscal year.
- For definitions of the Employee Classifications, please reference Section 24, starting on page 19 of the Instructions.

Section 27: Physicians with Admitting Privileges HAR p. 17

#4530 Physicians with Admitting Privileges: List only licensed physicians who have applied and been granted admitting privileges by the hospital’s Board of Directors.

Section 28: Teaching Hospital Medical Education Expenses HAR p. 17

Questions concerning Medical Education Expenses should be directed to the Health Economics Department at the Minnesota Department of Health at (651) 282-6367.

#5101 Full-Time Equivalent Resident: A graduate medical resident who is on assigned rotation at the hospital during the full reporting year. Full-time equivalent resident also means any combination of graduate medical residents who are on assigned rotation at the hospital during a portion of the reporting year for a combined amount of time equivalent to one resident for a full year. A graduate medical resident means an individual who is being trained as a physician and is in an accredited residency program at a teaching hospital.

#5102 Resident Salaries and Benefits: The total salaries or stipends paid to graduate medical residents, as well as costs for job-related benefits provided for residents, including health or disability insurance. Resident salaries and benefits include those salaries and benefits for the proportion of time on assigned rotation at the hospital, *regardless of whether the salaries and benefits are paid by the hospital or another entity.*

Section 29: Research Hospital Research Expenses: HAR p. 17

#5200 Research Expenses: The costs incurred by a facility for research purposes. Research means a systematic, intensive study directed toward a better scientific knowledge of the science and art of diagnosing, treating, curing, and preventing mental or physical disease, injury or deformity, relieving pain, and improving or preserving health. Research may be conducted at a laboratory bench without the use of patients or it may involve patients. Further more, there may be research projects that involve both laboratory bench research and patient care research.

Section 30: Administrative Expenses HAR p. 18

NOTE: The information reported in this section is classified as *nonpublic* data according to Minnesota Statutes, section 62J.321. This means it is not available to the public unless in

aggregate form.

The requirement for reporting administrative expenses differs depending on a hospital's number of licensed beds.

- Hospitals with fewer than 50 beds are required to report Total Administrative Expenses (Account 0630) only.
- Hospitals with 50 beds or greater are required to report Total Administrative Expenses (Account 0630) *and* expenses by functional categories (Accounts 0632 - 0641).

Report *hospital only* information. Record all direct and indirect expenses related to the line items listed below. Include Cost of Regulatory and Compliance Reporting, MIS, and Plant, Equipment and Occupancy Expenses as appropriate in Administrative Expenses.

The far right column on the formset shows a link labeled "Audit Check." Clicking on this link will take you to another tab in the workbook where you can review your Administrative Costs as a Percentage of Total Expense. This is for your information only to aid you in completion of the formset. If your hospital does not fall within the stated ranges, you may be contacted by MHA staff for possible corrections.

- #0632** Admitting, Patient Billing and Collection Expenses: All of the costs related to inpatient and outpatient admission or registration, whether scheduled or nonscheduled; the scheduling of admission times; insurance verification, including coordination of benefits; preparing and submitting claim forms; and cashiering, credit, and collections functions. Report all direct and indirect expenses *and* allocated amounts of 0637, 0650, and 0655 (if applicable).
- #0634** Accounting and Financial Reporting Expenses: All costs related to fiscal services, such as general accounting, budgeting, cost accounting, payroll accounting, accounts payable, fixed asset accounting, and inventory accounting. Report all direct and indirect expenses *and* allocated amounts of 0637, 0650, and 0655 (if applicable).
- #0635** Quality Assurance and Utilization Management Program/Activity Expenses: All costs associated with any activities or programs established for the purpose of quality of care evaluation and utilization management. Activities include quality assurance, development of practice protocols, utilization review, peer review, provider credential review, and all other medical care evaluation activities. Report all direct and indirect expenses *and* allocated amounts of 0637, 0650, and 0655 (if applicable).
- #0636** Community Wellness and Education Expenses: All the costs related to wellness programs, health promotion, community education classes, support groups, and other outreach programs and health screening included in a specific community or wellness education cost center or reclassified from other cost centers. Community and wellness education expenses do not include patient education programs. Report all direct and indirect expenses *and* allocated amounts of 0637, 0650, and 0655 (if applicable).
- #0639** Promotion and Marketing Expenses: All cost related to marketing, promotion, and advertising activities such as billboards, yellow page listing, cost of materials, advertising agency fees, marketing representative wages and fringe benefits, travel, and other expenses allocated to the promotion and marketing activities. Promotion and marketing

expenses does not include costs charged to other departments within the hospital. Report all direct and indirect expenses *and* allocated amounts of 0637, 0650, and 0655 (if applicable).

- #0647** Taxes, Fees, and Assessments: The direct payments made to government agencies including property taxes, medical care surcharge, MinnesotaCare tax, unrelated business income taxes, any assessments imposed by local, state, or federal jurisdiction, all fees associated with the facility's new or renewal certification with state or federal regulatory agencies, including fees associated with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation, and any fees or fines paid to government agencies for examinations related to regulation. Report all direct and indirect expenses *and* allocated amounts of 0637, 0650, and 0655 (if applicable).
- #0648** Malpractice Expenses: All costs of malpractice including malpractice insurance, self-insurance expenses including program administration, and malpractice losses not covered by insurance, including deductibles and malpractice attorney fees. Report all direct and indirect expenses *and* allocated amounts of 0637, 0650, and 0655 (if applicable).
- #0641** Other Administrative Expenses: All costs for the overall operation of the facility associated with management, administration, and legal staff functions, including the costs of governing boards, executive wages and benefits, auxiliary and other volunteer groups, purchasing, telecommunications, printing and duplicating, receiving and storing, and personnel management. Other administrative expenses includes all wages and benefits, donation and support, direct and in-kind, for the purpose of lobbying and influencing policy makers and legislators, including membership dues, and all expenses associated with public policy development, such as response to rulemaking and interaction with government agency personnel including attorney fees for reviewing analyzing governmental policies. Other administrative expenses *does not* include the costs of public relations included in promotion and marketing expenses, the cost of legal staff already allocated to other functions, or the costs of medical records, social services, and nursing administration. Report all direct and indirect expenses *and* allocated amounts of 0637, 0650, and 0655 (if applicable).
- #0630** Total Administrative Expenses: The sum of the following expenses:
- Admitting, patient billing, and collections (Account 0632)
 - Accounting and financial reporting (Account 0634)
 - Quality assurance and utilization management program or activity (Account 0635)
 - Community and wellness education (Account 0636)
 - Promotion and marketing (Account 0639)
 - Taxes, fees, and assessments (Account 0647)
 - Malpractice (Account 0648)
 - Other administrative expenses (Account 0641)

Section 31: Cost of Regulatory and Compliance Reporting HAR p. 18

The information reported in this section is classified as *nonpublic* data according to Minnesota Statutes, section 62J.321. This means it is not available to the public unless in aggregate form.

Note: Whenever reasonably possible, you are required to report **actual** numbers. If it is not reasonably possible, you may estimate using reasonable methods. Upon request, you must provide a written explanation of the method used for the estimate.

#0637 Total Cost of Regulatory and Compliance Reporting Expenses: All costs of the facility associated with, or directly incurred in the preparation and submission of financial, statistical, or other utilization, satisfaction, or quality reports, or summary plan descriptions that are required by federal, state, and local agencies. The portion of Account 0637 that is administrative expenses is to be reported in the breakouts of Account 0630 **and** included in the total of Account 0637.

Section 32: MIS and Occupancy Expenses HAR p. 18

The information reported in this section is classified as **nonpublic** data according to Minnesota Statutes, section 62J.321. This means it is not available to the public unless in aggregate form.

This section establishes the costs related to maintaining and operating a data processing system and the costs associated with plant, equipment and occupancy. The amounts reported for these accounts include the total estimated costs for **hospital only** expenses.

#0650 Total Management Information System Expenses: All costs related to maintaining and operating the data processing system of the facility, including such functions as admissions, medical records, patient charges, decision support systems, and fiscal services. The portion of Account 0650 that is administrative expenses is to be reported in the breakouts of Account 0630 **and** included in the total of Account 0650.

#0655 Total Plant, Equipment, and Occupancy Expenses: All costs related to plant, equipment, and occupancy expenses, including maintenance, repairs, and engineering expenses, building rent and leases, equipment rent and leases, and utilities. Plant, equipment, and occupancy expenses include interest expenses and depreciation. The portion of Account 0655 that is administrative expenses is to be reported in the breakouts of Account 0630 **and** included in the total of Account 0655.

Section 33: Top Ten Hospital DRGs by Total Discharges HAR p. 19

This section requires you to report the top ten DRGs for your hospital. The top ten DRGs are to be determined according to the **total number of discharges per DRG**. The DRG with the largest number of discharges is to be reported as number one, the DRG with the next largest number of discharges as number two, etc. in descending order. You are also required to report the associated total gross charges for each of the top ten DRGs reported.

Reporting this information is **mandatory**.

- If your hospital voluntarily reports to the UB92 data project (Minnesota Health Information Network - MHIN) sponsored by MHA, then MHA can report this

information for your hospital with your permission. If you want MHA to report this information for your hospital, you must check the box provided in the report. If you check this box, leave the rest of the page blank.

- If your hospital **does not** report to the UB92 data project cited above **or** you choose not to have MHA report for you, you must report this information yourself.

If you are unable to determine the actual total gross charges associated with each DRG, you may estimate using a reasonable method. One methodology is to determine an average charge per discharge for each DRG by taking a sample of bills for each DRG, totaling the charges and dividing by the number of bills. Multiply the average charge you calculated for the DRG by the total number of discharges for that DRG and the product is an estimated gross charge for the DRG. Other methods of estimation are acceptable if based on reasonable methods. Upon request, your facility must provide a written explanation of the method used for the estimate(s).

Section 34: Charity Care Costs and Policies HAR p. 20

This section requires you to report the costs associated with providing community services and charity care, and policies defining patient eligibility. All accounts in this section should be reported.

Charity Care: The total dollar amount that would have been charged for health care services that were provided with no expectation of cash inflows. Charity care results from a provider's policy to provide health care services free of charge or at a charge below the reasonable cost of the services to individuals who meet the provider's established criteria of inability to pay. Charity care is included in gross revenue from patient care and reported in the adjustments and uncollectibles summary.

#0884 Community Services Costs: Includes the actual costs of services and programs provided by a hospital to the community such as pharmacy consultations, infant car seat programs, disease-specific support groups, school education programs, food drives, community health screenings, health information, etc.

#7310 Charity Care Costs: This is automatically calculated. Calculation:
(0600/(0740+0770))*absolute value of 0762.

#0886 Cost in Excess of Public Program Payments: The cost in excess of public program payments for Medicare, Medical Assistance and MinnesotaCare Services. This is the hospital's best estimate of payments below cost for patient care provided to patients covered by Medicare, Medical Assistance programs and other governmental health coverage programs.

Section 35: Charity Care Summary HAR p. 20

Enter the number of charity care contacts and the corresponding amount of charity care provided by the breakouts of the family income of the patient in relation to the Federal Poverty Guideline (FPG).

Charity Care Contacts should be counted as 1 contact per Outpatient visit and 1 contact per Inpatient stay.

Note: The amount entered in #7057 should be the absolute value of the amount reported in account #0762. Charity care #7057 should be reported as a *positive* number.

Section 36: Patient Days by Hospital Service HAR p. 21

Enter the patient days by category including patient days for nursery, swing bed care and subacute/transitional care.

If you report patient days, you must also report corresponding charges and admissions.

#7227 Med/Surg Patient Days: Medical Surgical Patient Days includes routine care patient days for pediatric, adult and geriatric patients who are acutely ill or injured and in varying stages of recuperation from diagnostic, therapeutic or surgical interventions. This was formerly reported as 4001 Adult and Pediatric Patient Days.

#7151 ICU/CCU Patient Days: Includes Intensive Care Unit/Coronary Care Unit patient days. This line is the combination of former accounts 4004 Intensive Care Patient Days and 4007 Coronary Care Patient Days.

#4044 Neonatal (exclude routine nursery) Patient Days: Includes neonatal intensive care unit (NICU) patient days and all infant care patient days with care levels higher than a routine nursery.

Section 37: Specialty Care Patient Days HAR p. 21

#7252 Total Cardiac Care Patient Days: Patient Days relating to diseases and disorders of the Circulatory System and Heart Transplants

#7255 Total Orthopedic Care Patient Days: Patient Days relating to diseases and disorders of the Musculoskeletal System and Connective Tissue.

#7258 Total Neurology Care Patient Days: Patient Days relating to diseases and disorders of the Nervous System.

Section 38: Patient Days by Age HAR p. 21

#7245 Adult Care Patient Days (18+): Total Hospital Patient Days for all patients 18 years of age and older. This includes all Med/Surg, ICU/CCU, Chemical Dependency, Rehabilitation, Mental Health/Psych, Swing Bed and Transitional patient days.

#7248 Pediatric and Adolescent Patient Days (including Neonatal): Total Hospital Patient Days for all patients less than 18 years of age. This includes all Med/Surg, ICU/CCU, Nursery, Neonatal, Chemical Dependency, Rehabilitation, Mental Health/Psych, Swing and Transitional Bed patient days. This is *not* just for Pediatric specialty hospitals only. *This is to be completed by all hospitals.*

Section 39: Acute Patient Days by Primary Payer HAR p. 22
Exclude Swing Bed, Subacute/Transitional Care and Routine Nursery Days.

Enter the patient days by primary payer excluding patient days for nursery, swing bed care and subacute/transitional care.

If you report patient days, you must also report corresponding charges and admissions.

MDH is frequently asked to provide data on the utilization and financial trends for MA, GAMC, and MinnesotaCare. Eligibility and payment policies related to these programs vary greatly. It is important that these categories be separated, so that we have the ability to analyze trends by program types particularly as eligibility for the programs changes. This information is frequently requested by legislators and other state analysts to assist them in policy formation on a program level. With recent budget cuts, these requests have increased in frequency. This information needs to be collected separately, by program, for us to fulfill requests for data and to describe trends for each program.

#7277 Total Non-Managed Care Patient Days: Summary of three subsequent accounts: Medicare Patient Days (Non-Managed Care); MA/GAMC/MinnesotaCare Patient Days (Non-Managed Care); and Commercial Insurers, Nonprofit Health Plans Patient Days. This line does not need to be completed! It will populate itself as the subsequent lines are filled in.

#4022 MA/GAMC/MinnesotaCare Patient Days (Non-Managed Care): Total Patient Days for Medical Assistance, General Assistance, and MinnesotaCare Non-Managed Care patients. Hospitals that do not have program individual itemizations for the MA, GAMC and MinnesotaCare Non-Managed Care patients should leave the program specific lines blank and enter the total in this line.

#7159 MA Patient Days (Non-Managed Care): Patient Days for non-PMAP Medicaid Patients only.

#7160 GAMC Patient Days (Non-Managed Care): Patient Days for non-PGAMC General Assistance Medical Care Patients only.

#7161 MinnesotaCare Patient Days (Non-Managed Care): Patient Days for non-Prepaid MinnesotaCare Patients only.

#4023 Managed Care Organizations Patient Days: (For definitions of Managed Care Organizations, please refer to Section 9, page 13 of the Instructions.) These can include standard Managed Care Organizations such as Medica, Health Partners, etc. and also Prepaid Medicare and Medicaid companies.

#7162 Medicare Managed Care Patient Days: Patient Days for Prepaid Medicare Managed Care programs such as Medicare Plus Choice.

#7163 PMAP/PGAMC/MinnesotaCare Managed Care Patient Days: Total Patient Days for Prepaid Medical Assistance, Prepaid General Assistance, and Prepaid MinnesotaCare Managed Care Programs. Hospitals that do not have individual itemizations for PMAP, PGAMC and prepaid MinnesotaCare patients should leave the program specific lines blank and enter the total in this line. This cell is not locked.

#7164 PMAP Managed Care Patient Days: Patient Days for Prepaid Medical Assistance Program Medicaid Patients only.

- #7165 PGAMC Managed Care Patient Days: Patient Days for Prepaid General Assistance Medical Care Patients only.
- #7166 MinnesotaCare Managed Care Patient Days: Patient Days for Prepaid MinnesotaCare Patients only.
- #4026 Other Payers Patient Days: This category is for the payers that are not already identified in the breakouts for Non-Managed Care, Managed Care, and Individual (Self Pay). This would include Champus, Workman's Comp., Auto, etc. for each of the respective sections: Adjustments, Charges, Days, and Admissions. Please note that Commercial and Private payers are *not* reported on the Other Payers lines.

Section 40: Calculations based on Acute Patient Days HAR p. 22

#4060 Acute Adjusted Patient Days: This figure is a calculation that is used as an industry accepted way to standardize the per unit measure between hospitals allowing for the outpatient book of business. The adjustment factor is calculated by dividing Total Charges by Inpatient Charges. When this factor is multiplied by acute patient days, it provides a common denominator of units of service in terms of inpatient activity. This is automatically calculated. Calculation: $(0860/0851)*4030$.

Section 41: Daily Census HAR p. 22

In order to capture the capacity of a hospital, report on the daily census of your hospital. Exclude patient days for nursery, swing bed care and subacute/transitional care. Report the minimum and maximum census.

- #7058 Report the maximum daily census recorded in FY 2005.
- #7059 Report the minimum daily census recorded in FY 2005.

Section 42: Admissions by Hospital Service HAR p. 23

Enter the admissions by category including admissions for swing bed care, subacute/transitional care and births.

If you report admissions, you must also report corresponding patient days and patient charges.

#7228 Med/Surg Admissions: Medical Surgical Admissions includes routine care admissions for pediatric, adult and geriatric patients who are acutely ill or injured and in varying stages of recuperation from diagnostic, therapeutic or surgical interventions. This was formerly reported as 4301 Adult and Pediatric Admissions.

Section 43: Specialty Care Admissions HAR p. 23

#7268 Total Cardiac Care Admissions: Admissions relating to diseases and disorders of the

Circulatory System and Heart Transplants

#7271 Total Orthopedic Care Admissions: Admissions relating to diseases and disorders of the Musculoskeletal System and Connective Tissue.

#7274 Total Neurology Care Admissions: Admissions relating to diseases and disorders of the Nervous System.

Section 44: Admissions by Age HAR p. 23

#7261 Adult Care Admissions (18+): Total Hospital Admissions for all patients 18 years of age and older. This includes all Med/Surg, ICU/CCU, Chemical Dependency, Rehabilitation, Mental Health/Psych, Swing Bed and Transitional Admissions.

#7264 Pediatric and Adolescent Admissions (including Neonatal): Total Hospital Admissions for all patients less than 18 years of age. This includes all Med/Surg, ICU/CCU, Nursery, Neonatal, Chemical Dependency, Rehabilitation, Mental Health/Psych, Swing and Transitional Bed Admissions. This is *not* just for Pediatric specialty hospitals only. *This is to be completed by all hospitals.*

Section 45: Acute Admissions by Primary Payer HAR p. 24

Enter the admissions by category excluding admissions for swing bed care, subacute/transitional care and births.

#7279 Total Non-Managed Care Admissions: Summary of three subsequent accounts: Medicare Admissions (Non-Managed Care); MA/GAMC/MinnesotaCare Admissions (Non-Managed Care); and Commercial Insurers, Nonprofit Health Plans Admissions. This line does not need to be completed! It will populate itself as the subsequent lines are filled in.

MDH is frequently asked to provide data on the utilization and financial trends for MA, GAMC, and MinnesotaCare. Eligibility and payment policies related to these programs vary greatly. It is important that these categories be separated, so that we have the ability to analyze trends by program types particularly as eligibility for the programs change. This information is frequently requested by legislators and other state analysts to assist them in policy formation on a program level. With recent budget cuts, these requests have increased in frequency. This information needs to be collected separately, by program, for us to fulfill requests for data and to describe trends for each program.

#4342 MA/GAMC/MinnesotaCare Admissions (Non-Managed Care): Total Admissions for Medical Assistance, General Assistance, and MinnesotaCare Non-Managed Care patients. Hospitals that do not have program individual itemizations for the MA, GAMC and MinnesotaCare Non-Managed Care patients should leave the program specific lines blank and enter the total in this line. This cell is not locked.

#7181 MA Admissions (Non-Managed Care): Admissions for non-PMAP Medicaid Patients only.

#7182 GAMC Admissions (Non-Managed Care): Admissions for non-PGAMC General

Assistance Medical Care Patients only.

#7183 MinnesotaCare Patient Charges (Non-Managed Care): Admissions for non-Prepaid MinnesotaCare Patients only.

#4343 Managed Care Organizations Admissions:(For definitions of Managed Care Organizations, please refer to Section 9, page 13 of the Instructions.) These can include standard Managed Care Organizations such as Medica, Health Partners, etc. and also Prepaid Medicare and Medicaid companies.

#7184 Medicare Managed Care Admissions: Admissions for Medicare Managed Care programs such as Medicare Plus Choice.

#7185 PMAP/PGAMC/MinnesotaCare Managed Care Admissions: Total Admissions for Prepaid Medical Assistance, Prepaid General Assistance, and Prepaid MinnesotaCare Managed Care Programs. Hospitals that do not have program individual itemizations for PMAP, PGAMC and Prepaid MinnesotaCare patients should leave the program specific lines blank and enter the total in this line. This cell is not locked.

#7186 PMAP Managed Care Admissions: Admissions for Prepaid Medical Assistance Program Patients only.

#7187 PGAMC Managed Care Admissions: Admissions for Prepaid General Assistance Medical Care Patients only.

#7188 MinnesotaCare Managed Care Admissions: Admissions for Prepaid MinnesotaCare Patients only.

#4344 Other Payers Admissions: This category is for the payers that are not already identified in the breakouts for Non-Managed Care, Managed Care, and Individual (Self Pay). This would include Champus, Workman's Comp., Auto, etc. for each of the respective sections: Adjustments, Charges, Days, and Admissions. Please note that Commercial and Private payers are *not* reported on the Other Payers lines.

Section 46: Calculations based on Acute Care Admissions HAR p. 24

#4360 Acute Adjusted Patient Admissions: This figure is a calculation that is used as an industry accepted way to standardize the per unit measure between hospitals allowing for the outpatient book of business. The adjustment factor is calculated by dividing Total Charges by Inpatient Charges. When this factor is multiplied by acute admissions, it provides a common denominator of units of service in terms of inpatient activity. This is automatically calculated. Calculation: (0860/0851)*4340.

#4351 Average Length of Stay: This is automatically calculated. Calculation: (4030/4320).

SWING BED INFORMATION: HOSPITAL HAR p. 25

These sections pertain to the utilization of swing beds and are required by Minnesota Statutes, section 144.562, subdivision 3. Complete these sections *only* if services were provided in *Medicare approved* swing beds.

At the top of HAR page 25, a brief description of the types of services provided to patients in

swing beds is listed. Edit this description if your hospital varies from this service. Minnesota Statutes, section 144.562, subdivision 3(e)(2) requires this information.

Section 47: Number of Swing Beds HAR p. 25

#4550 Number of Swing Beds: A swing bed means a hospital bed licensed under Minnesota Statutes, sections 144.50 to 144.56 that has been granted a license condition under Minnesota Statutes, section 144.562 and which has been certified to participate in the federal Medicare program under United States Code, title 42, section 1395. Admission to a swing bed is limited to patients who have been hospitalized and not yet discharged from the hospital or patients who are transferred directly from an acute care hospital. Eligible hospitals are allowed a total of 1,460 days of swing bed use per year or an average of 4 beds, provided that no more than ten hospital beds are used for swing beds at any one time. Under new CMS rules, Critical Access Hospitals (CAH) may count up to 10 swing beds as part of their total licensed beds.

Section 48: Swing Bed Patient Days HAR p. 25

Do **not** include patient days for subacute or transitional care services not provided in a swing bed (see the next section for Subacute/Transitional Care Information).

#4033 Medicare Reimbursed Swing Bed Days: Swing bed patient days *reimbursed by Medicare for Medicare patients.*

#4035 Medicaid Reimbursed Swing Bed Days: Swing bed patient days that are *approved and reimbursed by Medicaid (Medical Assistance) for Medicaid (Medical Assistance) patients.* (Please note that only hospitals approved as *Sole Community Providers* are permitted to use swing beds for Medicaid patients.)

Section 49: Swing Bed Admissions by Origin HAR p. 25

#4326 Swing Bed Readmission: Readmission to a swing bed *within 60 days* of a patient's discharge from the facility.

Section 50: Swing Bed Discharges by Destination HAR p. 25

Swing Bed Discharges should approximate Swing Bed Admissions.

SUBACUTE/TRANSITIONAL CARE: HOSPITAL HAR p. 26

These sections pertain to the provision of subacute/transitional care and are required by Minnesota Statutes, section 144.564. These sections should be used to record all **non-acute** patient days that are **not** included as Swing Bed Days. All data in these sections must comply with the definition provided below.

Subacute/Transitional Care means care provided in a hospital bed to patients who have been hospitalized and no longer meet established acute care criteria. Subacute/transitional care also includes care provided to patients who are admitted for respite care. Do **not** include information about care provided in Medicare or Medicaid approved swing beds.

Section 51: Total Subacute/Transitional Care Patient Days HAR p. 26

Enter the patient days.

Section 52: Total Subacute/Transitional Care Beds HAR p. 26

#4540 Average Number of Subacute/Transitional Care Beds: This is automatically calculated. Calculation: (4037/365 days).

Section 53: Subacute/Transitional Care Admissions by Origin HAR p. 26

Enter the admissions by category.

Section 54: Subacute/Transitional Care Discharges by Destination HAR p. 26

Subacute/Transitional Care Discharges should approximate Subacute/Transitional Care Admissions.

Section 55: Facilities and Services Within the Hospital HAR pp. 27-29

Much attention has been focused in recent years on the proliferation of imaging technology and equipment around the state. The Minnesota Legislature has shown a keen interest in this topic, particularly around the issue of free-standing versus hospital based services. To provide timely and accurate information to policymakers and to properly analyze the situation, MDH needs more detailed information on the number of scanners at hospitals, the type of scanners (fixed vs. mobile), and the number of procedures being performed, therefore, some additional accounts have been added to the formset.

In this section you are to report the types of services the hospital offers by responding with the applicable number:

- 1 = The service is available **on site** at the hospital **and** provided by hospital staff.
- 2 = The service is **not available**.
- 3 = The service is available **on site** through contracted services.
- 4 = The service is available **off site** through shared services agreement.

For some services, you are only required to report whether the service is available. For other services, however, you are required to provide the utilization of that service as well as its

availability.

#6030 and 6034 Cardiac Catheterization Services: Includes the following ICD9-CM procedure codes: 35.96, 36.01, 36.02, 36.05, 36.09, 37.21, 37.22, 37.23, 37.26, 27.27, 37.34 and also the following radiology codes: 88.52, 88.53, 88.54, 88.55, 88.56, 88.57, 88.58. This includes the electrophysiology lab procedures.

#7206 Obstetrics Services: Any services involving the medical treatment of pregnant women or mothers following delivery.

#7207 Gynecology Services: Any therapeutic or diagnostic services to women with diseases or disorders of reproductive organs.

#6270 Organ Transplant Services: When reporting these services, count transplants, not surgeries. If the transplant surgery involved more than 1 transplant, report 1 for EACH applicable category.

#7210 Transportation Services (non-ambulance): A support service designed to assist the mobility of the patients to/from the hospital's facilities. It may include programs offering subsidies/vouchers for public transit use or separate vans or mini buses, financed and operated by the hospital or an affiliate for exclusive use by patients. This does *not* include Ambulance services.

#6290 Outpatient Medical Rehabilitation Services: Any rehabilitation service other than PT, OT, Speech, CD, or Psych.

Diagnostic Imaging Services

Combination (SPECT/CT and PET/CT) scanners and procedures should be reported on the specific combination line and *not* counted in the single (SPECT, CT, or PET) machine lines.

A heart study consisting of the stress test and resting non-stress test is counted as 2 procedures.

Section 56: Emergency Services/Department HAR pp. 30–31

This section requires you to report information about your hospital's emergency services department.

You are required to complete the remainder of this section.

#7001 Telemedicine Capabilities: (Telemedicine is the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care.

Section 57: Emergency Department Daily Staffing Patterns HAR p. 31

If you have a partial FTE for any given shift, *round up* to the next whole number.

If your shifts do not match the breakouts provided, use your best estimates to complete this section.

If your hospital is a Critical Access Hospital, and you staff Nurses (RN/LPN), Nurse

Practitioners, and Physician Assistants on call not on hospital premises, please complete appropriate lines for each of these on the formset.

Section 58: Summary of Outpatient Registrations HAR p. 31

Outpatient registrations represent the number of outpatient registrations as tabulated according to your hospital's established system. If modifications have been made to your hospital's registration system that result in a new method of counting, the modification should be documented and explained in the report.

The far right column on the formset shows a link labeled "Audit Check." Clicking on this link will take you to another tab in the workbook where you can review your Average Charge per Registration. The average range is also noted for you to compare your hospital with the state average. This is for your information only to aid you in completion of the formset. If your hospital does not fall within the stated ranges, you may be contacted by MHA staff for possible corrections.

- #4503** Total Number of Emergency Room Registrations (does not include those patients that leave before seeing a physician): This should represent the total number of ER visits **including** those admitted to the hospital. This **does not** include any patients that have been triaged and leave before seeing a physician.
- #4502** All Other Outpatient Registrations: Exclude the number of home health care and hospice visits.
- #4501** Total Outpatient Registrations: An outpatient registration means a documented acceptance of a patient by a facility for the purpose of providing outpatient services in an outpatient or ancillary department, including documented acceptance for the provision of emergency, observation and outpatient surgery services. An outpatient registration may involve the provision of more than one outpatient service and a patient may have more than one outpatient registration per day. Outpatient registration does **not** include failed appointments or telephone contacts. (Minnesota rules, part 4650.0102, subp. 30) Upper and lower GI outpatient diagnostic procedures (colonoscopy, sigmoidoscopy, etc.) should be included in this account. Exclude the numbers of home health care and hospice visits.
- #7044** Total Number of Patients Admitted to the Hospital Through the Emergency Department: This is a subcategory of account 4503 and is **required when applicable**.
- #7311** Total Number of Emergency Room Registrations that leave before seeing a physician (these are not included in 4503): This should represent the total number of ER visits that have registered, been triaged, and leave prior to being seen by a physician. Reporting this is **OPTIONAL**.

HAR Affiliated Clinic Information, or Provider Financial and Statistical Report (PFSR)

MinnesotaCare legislation authorizes the Minnesota Department of Health (MDH) to annually collect information from providers for the purpose of monitoring health care expenditures and trends. Physician group practices, health care clinics, and solo practitioners are required to complete this annual report, called the Provider Financial and Statistical Report, and return it to MDH (Minnesota Statutes, section 62J.301, subdivision 3, Minnesota Statutes, section 62J.41, and Minnesota Rules 1997, chapter 4651). MDH has collected this data in past years from health care providers and payers, which has been useful to inform policymakers about issues and trends in Minnesota's health care marketplace. We have estimated total health care spending within the state, calculated the proportion attributed to physician services, and analyzed uncompensated care in Minnesota. Future reports mandated by the legislature will also use information from the Provider Financial and Statistical Report.

In previous years, clinics affiliated with a hospital have elected to report this information on the Hospital Annual Report (as Affiliated Clinic Information) instead of filing the PFSR form. To streamline data collection and analysis, MDH requests that hospital-affiliated clinic facilities use the PFSR format for submitting the affiliated clinic data.

A new format has been implemented for the PFSR, which utilizes a database scanning system. This form is sent in a mailing to those organizations that are part of a sampled number of provider organizations currently being asked to submit these data to MDH. The form is only available in hardcopy. If you are not sure whether your organization is required to submit the PFSR data (Affiliated Clinic Information) please feel free to contact the Center for Data Initiatives at 651-201-3570. If you have questions about preparing or submitting the data, or need to obtain the report form for submitting the PFSR (Affiliated Clinic Information), please feel free to contact the MDH Center for Data Initiatives at 651-201-3570, or send an email to Catherine.malave@health.state.mn.us. Also, you may visit this page at the MDH website for further information: www.health.state.mn.us/divs/hpsc/hep.